

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2024 CERTIFICATE OF DEATH

02003

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Va. b. COUNTY Lucker ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller				c. LENGTH OF STAY IN 1b 2 mo.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Thomas 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Rose Last AVONA			4. DATE OF DEATH Month Feb. Day 9 Year 1960				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2, 1882	
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy	
13. FATHER'S NAME Guy Pirrera				14. MOTHER'S MAIDEN NAME Rose Cordoro			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Fred Pratt, Kitzmiller, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary of heart with arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus						INTERVAL BETWEEN ONSET AND DEATH 2 days ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 7, 1960 , to Feb. 9, 1960 , that I last saw the deceased alive on Feb. 9, 1960 , and that death occurred at 3:30 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Ralph Calandrella				ADDRESS (Street, city or town, state) Kitzmiller, Md. DATE SIGNED Feb. 9-60			
PHYSICIAN'S NAME (Type) RALPH CALANDRELLA				Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/12/60		22c. NAME OF CEMETERY OR CREMATORY Catholic Cem.		22d. LOCATION (City, town, or county) (State) Thomas W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE J. W. Hance				ADDRESS Thomas, W. Va.		24a. REC'D BY REGISTRAR DATE FEB 12 '60	
						24b. REGISTRAR'S SIGNATURE J. S. Hance	

1 hours after death: Page 4 TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. The low requires that the death certificate be executed within 72 hours after death. The low requires that the death certificate be executed within 72 hours after death. may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. VS A15 (4) 15M 10/57

2023

CERTIFICATE OF DEATH

02004

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Swanton</u>				c. LENGTH OF STAY IN TB <u>85 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Tryphena</u> Middle <u>May</u> Last <u>Beckman</u>				4. DATE OF DEATH Month <u>2</u> Day <u>8</u> Year <u>19 60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 3, 1874</u>	
9. AGE (In years last birthday) <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John L. Fitzwater</u>				14. MOTHER'S MAIDEN NAME <u>Hephzibah George</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Edith O'Brien</u> Address <u>Rural Swanton, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Starvation</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Uremia</u> DUE TO (c) <u>Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>2 weeks</u> <u>Year</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-27, 1950</u> , to <u>1-30, 1960</u> , that I last saw the deceased alive on <u>1-30, 1960</u> , and that death occurred at <u>10 p.m.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u> M.D.				ADDRESS (Street, city or town, state) <u>Oakland, Md.</u> DATE SIGNED <u>2-10-60</u>			
PHYSICIAN'S NAME (Type) <u>JAMES H. FEASTER JR.</u>				PHYSICIAN'S NAME (Type) <u>Oakland, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/11/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Garrett Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnich Funeral Home</u>				ADDRESS <u>Oakland, Maryland</u>		24a. REC'D BY REGISTRAR <u>FEB 17 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR AIS (4)
15M 9/59

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2025

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

02005

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Bloomington		c. LENGTH OF STAY IN 1b 30 Yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 Mi. W. Bloomington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Bloomington	
		d. STREET ADDRESS 2 Mi W. Bloomington	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Elizabeth Last Bever		4. DATE OF DEATH Month Feb. Day 21 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1904
9. AGE (In years lost birthday) 55 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Fox		14. MOTHER'S MAIDEN NAME Rada Whinner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT George Pever-Bloomington, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Large bowel 153.9 DUE TO Carcinomatosis, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO Cirrhosis., of Liver (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Pyra 8mo 6mo			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 20 19 59 to Feb 21 19 60 that (I) (we) last saw the deceased alive on Feb 20 19 60 , and that death occurred at IIM , from the causes and on the date stated above.			
22a. SIGNATURE James H. Wolverton Sr		22b. DATE SIGNED 2/22/60	
22c. PHYSICIAN'S NAME (Type) James H Wolverton Sr Md		22d. ADDRESS 20 Green St - Piedmont W Va.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/23.60	
23c. NAME OF CEMETERY OR CREMATORY George Bever Family Cem.		23d. LOCATION (City, town, or county) (State) (near) Bloomington Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Est. Boal		25a. REC'D BY REGISTRAR DATE FEB 25 '60	
ADDRESS Westernport, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2010 CERTIFICATE OF DEATH

02006

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 2½ DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				d. STREET ADDRESS ROUTE #1			
3. NAME OF DECEASED (Type or print) First JONAS Middle EARL Last BUTLER				4. DATE OF DEATH Month FEBRUARY Day 6TH Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 15, 1893	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME MC CLELLAND GIDEON BUTLER				14. MOTHER'S MAIDEN NAME ELIZA ELLEN FULK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 181-18-5591		17. INFORMANT GRAHAM WEEKS, OAKLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pneumonia, Bilateral 493X DUE TO And Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Congestive Heart Failure DUE TO And (c) Uremia - Chronic Pyelonephritis INTERVAL BETWEEN ONSET AND DEATH 4 days 3 days 6 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peritonitis of the Liver with Abscess							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Aug 29, 1960 , to February 6, 1960 , that I last saw the deceased alive on February 6, 1960 , and that death occurred at 11:15P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert H. Leighton M.D.				ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md. DATE SIGNED Feb 11 '60			
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.				OAKLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/9/60		22c. NAME OF CEMETERY OR CREMATORY OAK GROVE		22d. LOCATION (City, town, or county) (State) RURAL GRANTSVILLE GARRETT Co MD	
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman				ADDRESS Grantsville, Md.		24a. REC'D BY REGISTRAR DATE FEB 11 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Hines			

2018 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Page 001 of 01

1. NAME OF DECEASED [REDACTED]		2. DATE OF DEATH [REDACTED]	
3. PLACE OF DEATH [REDACTED]		4. COUNTY OF DEATH [REDACTED]	
5. SEX [REDACTED]		6. AGE [REDACTED]	
7. RACE [REDACTED]		8. MARITAL STATUS [REDACTED]	
9. OCCUPATION [REDACTED]		10. EDUCATION [REDACTED]	
11. SOCIAL SECURITY NUMBER [REDACTED]		12. MEDICAL HISTORY [REDACTED]	
13. CAUSE OF DEATH [REDACTED]		14. MANNER OF DEATH [REDACTED]	
15. SIGNATURE OF DECEASED [REDACTED]		16. SIGNATURE OF WITNESS [REDACTED]	
17. SIGNATURE OF PHYSICIAN [REDACTED]		18. SIGNATURE OF CORONER [REDACTED]	
19. SIGNATURE OF JUDGE [REDACTED]		20. SIGNATURE OF CLERK [REDACTED]	
21. SIGNATURE OF DECEASED [REDACTED]		22. SIGNATURE OF WITNESS [REDACTED]	
23. SIGNATURE OF PHYSICIAN [REDACTED]		24. SIGNATURE OF CORONER [REDACTED]	
25. SIGNATURE OF JUDGE [REDACTED]		26. SIGNATURE OF CLERK [REDACTED]	
27. SIGNATURE OF DECEASED [REDACTED]		28. SIGNATURE OF WITNESS [REDACTED]	
29. SIGNATURE OF PHYSICIAN [REDACTED]		30. SIGNATURE OF CORONER [REDACTED]	
31. SIGNATURE OF JUDGE [REDACTED]		32. SIGNATURE OF CLERK [REDACTED]	
33. SIGNATURE OF DECEASED [REDACTED]		34. SIGNATURE OF WITNESS [REDACTED]	
35. SIGNATURE OF PHYSICIAN [REDACTED]		36. SIGNATURE OF CORONER [REDACTED]	
37. SIGNATURE OF JUDGE [REDACTED]		38. SIGNATURE OF CLERK [REDACTED]	
39. SIGNATURE OF DECEASED [REDACTED]		40. SIGNATURE OF WITNESS [REDACTED]	
41. SIGNATURE OF PHYSICIAN [REDACTED]		42. SIGNATURE OF CORONER [REDACTED]	
43. SIGNATURE OF JUDGE [REDACTED]		44. SIGNATURE OF CLERK [REDACTED]	
45. SIGNATURE OF DECEASED [REDACTED]		46. SIGNATURE OF WITNESS [REDACTED]	
47. SIGNATURE OF PHYSICIAN [REDACTED]		48. SIGNATURE OF CORONER [REDACTED]	
49. SIGNATURE OF JUDGE [REDACTED]		50. SIGNATURE OF CLERK [REDACTED]	
51. SIGNATURE OF DECEASED [REDACTED]		52. SIGNATURE OF WITNESS [REDACTED]	
53. SIGNATURE OF PHYSICIAN [REDACTED]		54. SIGNATURE OF CORONER [REDACTED]	
55. SIGNATURE OF JUDGE [REDACTED]		56. SIGNATURE OF CLERK [REDACTED]	
57. SIGNATURE OF DECEASED [REDACTED]		58. SIGNATURE OF WITNESS [REDACTED]	
59. SIGNATURE OF PHYSICIAN [REDACTED]		60. SIGNATURE OF CORONER [REDACTED]	
61. SIGNATURE OF JUDGE [REDACTED]		62. SIGNATURE OF CLERK [REDACTED]	
63. SIGNATURE OF DECEASED [REDACTED]		64. SIGNATURE OF WITNESS [REDACTED]	
65. SIGNATURE OF PHYSICIAN [REDACTED]		66. SIGNATURE OF CORONER [REDACTED]	
67. SIGNATURE OF JUDGE [REDACTED]		68. SIGNATURE OF CLERK [REDACTED]	
69. SIGNATURE OF DECEASED [REDACTED]		70. SIGNATURE OF WITNESS [REDACTED]	
71. SIGNATURE OF PHYSICIAN [REDACTED]		72. SIGNATURE OF CORONER [REDACTED]	
73. SIGNATURE OF JUDGE [REDACTED]		74. SIGNATURE OF CLERK [REDACTED]	
75. SIGNATURE OF DECEASED [REDACTED]		76. SIGNATURE OF WITNESS [REDACTED]	
77. SIGNATURE OF PHYSICIAN [REDACTED]		78. SIGNATURE OF CORONER [REDACTED]	
79. SIGNATURE OF JUDGE [REDACTED]		80. SIGNATURE OF CLERK [REDACTED]	
81. SIGNATURE OF DECEASED [REDACTED]		82. SIGNATURE OF WITNESS [REDACTED]	
83. SIGNATURE OF PHYSICIAN [REDACTED]		84. SIGNATURE OF CORONER [REDACTED]	
85. SIGNATURE OF JUDGE [REDACTED]		86. SIGNATURE OF CLERK [REDACTED]	
87. SIGNATURE OF DECEASED [REDACTED]		88. SIGNATURE OF WITNESS [REDACTED]	
89. SIGNATURE OF PHYSICIAN [REDACTED]		90. SIGNATURE OF CORONER [REDACTED]	
91. SIGNATURE OF JUDGE [REDACTED]		92. SIGNATURE OF CLERK [REDACTED]	
93. SIGNATURE OF DECEASED [REDACTED]		94. SIGNATURE OF WITNESS [REDACTED]	
95. SIGNATURE OF PHYSICIAN [REDACTED]		96. SIGNATURE OF CORONER [REDACTED]	
97. SIGNATURE OF JUDGE [REDACTED]		98. SIGNATURE OF CLERK [REDACTED]	
99. SIGNATURE OF DECEASED [REDACTED]		100. SIGNATURE OF WITNESS [REDACTED]	



1. This is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the [REDACTED] day of [REDACTED], 2018.

2. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the [REDACTED] day of [REDACTED], 2018.

3. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the [REDACTED] day of [REDACTED], 2018.

4. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the [REDACTED] day of [REDACTED], 2018.

5. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the [REDACTED] day of [REDACTED], 2018.

6. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the [REDACTED] day of [REDACTED], 2018.

7. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the [REDACTED] day of [REDACTED], 2018.

8. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the [REDACTED] day of [REDACTED], 2018.

9. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the [REDACTED] day of [REDACTED], 2018.

10. I hereby certify that the above is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, on the [REDACTED] day of [REDACTED], 2018.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9 Film G257 2-29-60 et

2011

CERTIFICATE OF DEATH

02007

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND, MARYLAND		c. LENGTH OF STAY IN 1b 11 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRISON William CASTEEL		4. DATE OF DEATH Month FEBRUARY Day 16 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DECEMBER 31, 1879
9a. AGE (In years last birthday) 80 yrs.		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer Timber work		10b. KIND OF BUSINESS OR INDUSTRY work in woods	
11. BIRTHPLACE (State or foreign country) SANG RUN, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME JOHN CASTEEL		14. MOTHER'S MAIDEN NAME LUCY DE WITT	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-2811	
17. INFORMANT CLARENCE CASTEEL		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis, bilateral 480X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Influenza DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 weeks 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia - Chronic		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 5, 1960 , to February 16, 1960 , that I last saw the deceased alive on February 16, 1960 , and that death occurred at 5:50 PM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton		DATE SIGNED 17 Feb 60	
PHYSICIAN'S NAME (Type) DR. HERBERT H. LEIGHTON		OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/19/1960	
22c. NAME OF CEMETERY OR CREMATORY Sang Run Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE FEB 24 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hume	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN J. ROY		2. SEX MALE		3. AGE 68	
4. DATE OF DEATH 10-10-1981		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH HOME	
7. CAUSE OF DEATH HEART DISEASE		8. MANNER OF DEATH NATURAL		9. SIGNATURE OF PHYSICIAN [Signature]	
10. SIGNATURE OF REGISTRAR [Signature]		11. SIGNATURE OF WITNESS [Signature]		12. SIGNATURE OF DECEASED [Signature]	

10-10-1981

10-10-1981

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital at the attending physician's request. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02008

2012 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. LENGTH OF STAY IN 1b 16 DAYS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GEORGE Middle X C. Last CHANEY		4. DATE OF DEATH Month FEB. Day 28 Year 19 60	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 1, 1892
9. AGE (In years last birthday) yrs. 67		10. USUAL OCCUPATION (Give kind of work done during part of working life, even if retired) Carpenter Construction Work	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Isaac		14. MOTHER'S MAIDEN NAME Mariah Haines	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W.#1		16. SOCIAL SECURITY NO. 214-20-4363	
17. INFORMANT (SELF) GEORGE CHANEY		Address MT. LAKE PARK, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X Thrombia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Anasarca - Pleural, Peritoneal, Peripheral DUE TO (c) Cardio - Renal Insufficiency - Chronic INTERVAL BETWEEN ONSET AND DEATH 2 weeks 15 days 5 years or more			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March , 19 57 , to Feb 28 , 19 60 , that I last saw the deceased alive on Feb 27 , 19 60 , and that death occurred at 1:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton		ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md. DATE SIGNED 29 Feb 60	
PHYSICIAN'S NAME (Type) DR. HERBERT H. LEIGHTON		OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/2/1960	22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem. 5501 Frederick Ave.	
22d. LOCATION Baltimore, Md. (State)			
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR MAR 2 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Hanks	

CERTIFICATE OF BIRTH

20
1944

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

DATE OF INTERMENT

PLACE OF INTERMENT

DATE OF CREMATION

PLACE OF CREMATION

DATE OF REINTERMENT

PLACE OF REINTERMENT

DATE OF RECREMATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02009

Reg. Dist. No.

2013				2013			
1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>6 mos.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Oakland, Maryland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>				e. STREET ADDRESS <u>/</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>O.</u> Last <u>Cheratti</u>				4. DATE OF DEATH Month <u>February</u> Day <u>1</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/24/1884</u>		9. AGE (In years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Mining</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Unk.</u>				14. MOTHER'S MAIDEN NAME <u>Unk.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk</u>		16. SOCIAL SECURITY NO. <u>167-07-8868</u>		17. INFORMANT Address <u>Mrs. Bess Cuppett, Oakland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, terminal</u> DUE TO (b) <u>Leukemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) _____ 204.4						INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dr. J. H. Feaster, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr. J. H. Feaster, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-3-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) _____ (State) <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnich Funeral Home</u>				ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR <u>DATE FEB 4 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Keane</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Delay is necessary, please execute the certificate, writing the "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE DEPARTMENT OF HEALTH-BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 10 1900		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		DISEASE		INJURY	
1000 N. E. ST.		LABORER		HEART DISEASE		NATURAL		CORONARY ARTERY DISEASE		NONE	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		RELIGION		MARRIAGE		SINGLE	
JAN 10 1855		BALTIMORE, MD.		HIGH SCHOOL		METHODIST		MARRIED		NONE	
FATHER'S NAME		MOTHER'S NAME		DATE OF MARRIAGE		PLACE OF MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		MARY H. HARRIS		JAN 10 1880		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
LABORER		LABORER		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S RESIDENCE		MOTHER'S RESIDENCE		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
1000 N. E. ST.		1000 N. E. ST.		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JAN 10 1825		JAN 10 1835		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
BALTIMORE, MD.		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JAN 10 1880		JAN 10 1880		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
BALTIMORE, MD.		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		HEART DISEASE		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
NATURAL		NATURAL		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S DISEASE		MOTHER'S DISEASE		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S INJURY		MOTHER'S INJURY		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
NONE		NONE		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S DATE OF BIRTH		MOTHER'S DATE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JAN 10 1825		JAN 10 1835		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
BALTIMORE, MD.		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
JAN 10 1880		JAN 10 1880		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S PLACE OF DEATH		MOTHER'S PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
BALTIMORE, MD.		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S CAUSE OF DEATH		MOTHER'S CAUSE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
HEART DISEASE		HEART DISEASE		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S MANNER OF DEATH		MOTHER'S MANNER OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
NATURAL		NATURAL		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S DISEASE		MOTHER'S DISEASE		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
CORONARY ARTERY DISEASE		CORONARY ARTERY DISEASE		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	
FATHER'S INJURY		MOTHER'S INJURY		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
NONE		NONE		JAN 10 1900		BALTIMORE, MD.		JAN 10 1900		BALTIMORE, MD.	

TO BE FILLED BY THE MEDICAL EXAMINER. This certificate is to be filed in the office of the Medical Examiner, Baltimore, Maryland, and a copy of the same is to be sent to the State Department of Health, Baltimore, Maryland.

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0102-2

VS A15 (4)
15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital and the attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

20210

2014

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>1 Mo.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weeks Nursing Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
3. NAME OF DECEASED (Type or print) <u>Janet</u> First Middle Last <u>Coyle</u>		4. DATE OF DEATH Month <u>Feb.</u> Day <u>18</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12, 1875</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>84</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mesiah Preston</u>		14. MOTHER'S MAIDEN NAME <u>Anna Greenhorn</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. William Varner—Cumberland, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonitis, terminal</u> <u>433.1</u> DUE TO <u>Auricular fibrillation, 2 months</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Arteriosclerosis, generalized,</u> DUE TO (c) <u>2 months years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral vascular accident, right, years ago</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-15-</u> 19 <u>60</u> to <u>2-18-60</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-17-60</u> , 19 <u>60</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>58 2nd. St., Oakland, Md. 2-19-60</u>	
PHYSICIAN'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/21/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Philos</u>	22d. LOCATION (City, town, or county) (State) <u>Westernport Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>E. L. Boal</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 23 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>

.....

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2015 CERTIFICATE OF DEATH

02011

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 72 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 63 Wilson St.		d. STREET ADDRESS 63 Wilson St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Wilbur Middle Lawton Last Davis		4. DATE OF DEATH Month February Day 29 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1887
9. AGE (In years last birthday) yrs. 72		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance work for Gas Co.		10b. KIND OF BUSINESS OR INDUSTRY Gas Co.	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles S. Davis		14. MOTHER'S MAIDEN NAME Sarah Lawton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. --	
17. INFORMANT Richard Davis		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation, Auto 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 hour Years			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1953 , 19 to Feb 20, 1960 , that I last saw the deceased alive on Jan 20, 1960 , and that death occurred at 4:30 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 21st Oak Hill Rd DATE SIGNED 3-2-60			
ACTUAL SIGNATURE James H. Feaster Jr. M.D.		PHYSICIAN'S NAME (Type) James H. Feaster Jr., M. D. Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/3/1960	
22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. E. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE MAR 7 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

BP

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES EARL RAY		35		M		W		1928		MOBILE, ALABAMA	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		DATE OF DEATH		PLACE OF DEATH	
MEMPHIS, TENNESSEE		ATTORNEY		HIGH SCHOOL		MARRIED		4/4/68		MEMPHIS, TENNESSEE	
CAUSE OF DEATH		MANNER OF DEATH		CERTIFICATE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH	
HEART DISEASE		NATURAL		1		4/4/68		MEMPHIS, TENNESSEE		4/4/68	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF DEATH REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH		DATE OF DEATH		PLACE OF DEATH	
4/4/68		MEMPHIS, TENNESSEE		4/4/68		MEMPHIS, TENNESSEE		4/4/68		MEMPHIS, TENNESSEE	

2027

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deer Park Rt #2</u>				c. LENGTH OF STAY IN 1b <u>1 day</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Ellen</u> Last <u>Fike</u>				4. DATE OF DEATH Month <u>2</u> Day <u>23</u> Year <u>19 60</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 3, 1875</u>		9. AGE (In years last birthday) <u>84</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Moyes, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Conway</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Lininger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT <u>Mildred Hoyer</u> Address <u>Deer Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Heart Disease</u> DUE TO (c) <u>Hypertension</u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1950</u> , to <u>Feb 23, 1960</u> , that I last saw the deceased alive on <u>Feb. 12, 1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Ralph Calandrella</u> M.D. <u> </u> <u>Feb. 27-60</u>				PHYSICIAN'S NAME (Type) <u>RALPH CALANDRELLA</u> <u> </u> <u>M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>2/26/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Steele Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Friendsville, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Linnich Funeral Home</u> ADDRESS <u>Oakland, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 2 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Evans</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH		5. TIME OF DEATH	
6. PLACE OF DEATH		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF BURIAL		10. NAME OF MINISTER	
11. NAME OF PHYSICIAN		12. NAME OF SURGEON		13. NAME OF MIDWIFE		14. NAME OF NURSE		15. NAME OF ATTENDING CLERGY	
16. NAME OF CORONER		17. NAME OF JURY		18. NAME OF JUDGE		19. NAME OF CLERK		20. NAME OF REGISTRAR	
21. NAME OF WITNESS		22. NAME OF WITNESS		23. NAME OF WITNESS		24. NAME OF WITNESS		25. NAME OF WITNESS	
26. NAME OF WITNESS		27. NAME OF WITNESS		28. NAME OF WITNESS		29. NAME OF WITNESS		30. NAME OF WITNESS	
31. NAME OF WITNESS		32. NAME OF WITNESS		33. NAME OF WITNESS		34. NAME OF WITNESS		35. NAME OF WITNESS	
36. NAME OF WITNESS		37. NAME OF WITNESS		38. NAME OF WITNESS		39. NAME OF WITNESS		40. NAME OF WITNESS	
41. NAME OF WITNESS		42. NAME OF WITNESS		43. NAME OF WITNESS		44. NAME OF WITNESS		45. NAME OF WITNESS	
46. NAME OF WITNESS		47. NAME OF WITNESS		48. NAME OF WITNESS		49. NAME OF WITNESS		50. NAME OF WITNESS	
51. NAME OF WITNESS		52. NAME OF WITNESS		53. NAME OF WITNESS		54. NAME OF WITNESS		55. NAME OF WITNESS	
56. NAME OF WITNESS		57. NAME OF WITNESS		58. NAME OF WITNESS		59. NAME OF WITNESS		60. NAME OF WITNESS	
61. NAME OF WITNESS		62. NAME OF WITNESS		63. NAME OF WITNESS		64. NAME OF WITNESS		65. NAME OF WITNESS	
66. NAME OF WITNESS		67. NAME OF WITNESS		68. NAME OF WITNESS		69. NAME OF WITNESS		70. NAME OF WITNESS	
71. NAME OF WITNESS		72. NAME OF WITNESS		73. NAME OF WITNESS		74. NAME OF WITNESS		75. NAME OF WITNESS	
76. NAME OF WITNESS		77. NAME OF WITNESS		78. NAME OF WITNESS		79. NAME OF WITNESS		80. NAME OF WITNESS	
81. NAME OF WITNESS		82. NAME OF WITNESS		83. NAME OF WITNESS		84. NAME OF WITNESS		85. NAME OF WITNESS	
86. NAME OF WITNESS		87. NAME OF WITNESS		88. NAME OF WITNESS		89. NAME OF WITNESS		90. NAME OF WITNESS	
91. NAME OF WITNESS		92. NAME OF WITNESS		93. NAME OF WITNESS		94. NAME OF WITNESS		95. NAME OF WITNESS	
96. NAME OF WITNESS		97. NAME OF WITNESS		98. NAME OF WITNESS		99. NAME OF WITNESS		100. NAME OF WITNESS	

AMT BOND

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02013

2016 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 18 Mo.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Rachel Middle Hoff Last Frantz		4. DATE OF DEATH Month February Day 6, Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 1, 1873
9. AGE (In years last birthday) yrs. 86		IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min. 86	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benjamin Hoff		14. MOTHER'S MAIDEN NAME Rebecca Ringer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Merle D. Frantz		Address Friendsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIA 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROSIS DUE TO (c) ARTERIOSCLEROSIS PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROSIS INTERVAL BETWEEN ONSET AND DEATH 10 days YEARS			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 1959 to Mar 4, 1960 , that I last saw the deceased alive on Feb. 4, 1960 , and that death occurred at 9:20P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 21st - Oakland - Md. DATE SIGNED 2-7-60			
ACTUAL SIGNATURE James H. Feaster Jr. M.D.			
PHYSICIAN'S NAME (Type) James H. Feaster Jr., M. D. Oakland, Maryland.			
22a. BURIAL, CREMATION, RECOVERY (Specify) Burial		22b. DATE THEREOF 2/9/1960	
22c. NAME OF CEMETERY OR CREMATORY Blooming Rose Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur L. Kraus		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE FEB 10 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John J. Smith		Male		45	
Place of Birth		Date of Birth		Date of Death	
St. Louis, Mo.		Jan. 1, 1880		Jan. 15, 1925	
Cause of Death		Disease		Occupation	
Heart Disease		Coronary Artery Disease		Farmer	
Duration of Illness		Time of Day		Place of Death	
One Week		10:00 AM		Home	
Physician		Funeral Home		Burial Place	
Dr. J. H. Jones		Smith & Son		St. Louis, Mo.	
Signature of Physician		Signature of Funeral Home		Signature of Burial Place	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Issued by		Official Seal	
Jan. 16, 1925		J. H. Jones		[Seal]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2017 CERTIFICATE OF DEATH

02014

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>3 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Evans Nursing Home</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Friendsville</u>	
		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Truman</u> <u>Friend</u>		4. DATE OF DEATH Month Day Year <u>2</u> <u>10</u> <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 2, 1868</u>
9. AGE (In years last birthday) <u>91</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>unk.</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Friend</u>		14. MOTHER'S MAIDEN NAME <u>Rachael Jenkins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>unk.</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Mrs. M. Jones</u>		Address <u>Friendsville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONITIS, terminal</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Senility</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Senility</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1-7</u> , 19 <u>57</u> , to <u>2-8</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-8</u> , 19 <u>60</u> , and that death occurred at <u>8:10 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Friendsville, Maryland</u> <u>2-10-60</u>			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D.		PHYSICIAN'S NAME (Type) <u>JAMES H. FEASTER, JR., M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/12/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Steele Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Friendsville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnich Funeral Home</u>		ADDRESS <u>Oakland, Maryland</u>	
24a. REC'D BY REGISTRAR <u>FEB 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2018 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02015

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>			c. LENGTH OF STAY IN 1b <u>mins.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Mt. Lake Park</u>					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>E</u> Last <u>Hubbard</u>				4. DATE OF DEATH Month <u>2</u> Day <u>21</u> Year <u>1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 1, 1891</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Brick Layer P.O. Building</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>JOHN HUBBARD</u>				14. MOTHER'S MAIDEN NAME <u>CATHERINE DOWNS</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT Address <u>LILLIAN I. MASON 7407 SCHOOL AVE #22</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Decompensation, Pulmonary Edema</u> <u>526X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cor Pulmonale</u> DUE TO (c) <u>Bronchiectasis, bilateral; marked</u> </div> <div style="width: 15%;"> INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> ----- <u>years</u> </div> </div>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>2-21-60</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>2-24-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN CEM.</u>		22d. LOCATION (City, town, or county) (State) <u>7225 EASTERN BLVD. BALTO Co., MD.</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles S. Feiler</u>				ADDRESS <u>901 S. CONKLING ST. BALTO., 24, MD.</u>		24a. REC'D BY REGISTRAR <u>FEB 25 1960</u>		24b. REGISTRAR'S SIGNATURE <u> </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2019 CERTIFICATE OF DEATH

Reg. Dist. No.

02016

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Allegany ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland, 0102.2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		e. STREET ADDRESS 323 Baltimore Ave.	
3. NAME OF DECEASED (Type or print) First Blanche Middle Hughes Last Hughes		4. DATE OF DEATH Month February Day 21 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 24, 1905
9. AGE (In years last birthday) yrs. 54		IF UNDER 1 YEAR Months 1 Days 19 Hours 60 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Hughes		14. MOTHER'S MAIDEN NAME Mae Hitchins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Harry Hughes		Cumberland, Md. Cash Valley Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 442 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Auricular fibrillation DUE TO (c) Arteriosclerotic, cardio-renal disease.			INTERVAL BETWEEN ONSET AND DEATH 2 weeks years "
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-19-59 , 19____, to 2-18-60 , 19____, that last saw the deceased alive on 2-18-60 , 19____, and that death occurred at 10:45 P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Oakland, Md. 2-22-60			
ACTUAL SIGNATURE James H. Feaster Jr. M.D.		PHYSICIAN'S NAME (Type) James H. Feaster Jr., M.D. Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/24/1960	22c. NAME OF CEMETERY OR CREMATORY Frostburg Mem. Park	22d. LOCATION (City, town, or county) (State) Frostburg, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Duntz		ADDRESS Frostburg, Md.	
24a. REC'D BY REGISTRAR FEB 25 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2010



<p>NAME OF DECEASED [Illegible Name]</p>		<p>AGE [Illegible Age]</p>	
<p>SEX [Illegible Sex]</p>		<p>RACE [Illegible Race]</p>	
<p>DATE OF DEATH [Illegible Date]</p>		<p>TIME OF DEATH [Illegible Time]</p>	
<p>PLACE OF DEATH [Illegible Place]</p>		<p>CAUSE OF DEATH [Illegible Cause]</p>	
<p>DIAGNOSIS [Illegible Diagnosis]</p>		<p>DATE OF BIRTH [Illegible Date]</p>	
<p>PLACE OF BIRTH [Illegible Place]</p>		<p>DATE OF DEATH [Illegible Date]</p>	
<p>NAME OF PHYSICIAN [Illegible Name]</p>		<p>NAME OF REGISTRAR [Illegible Name]</p>	
<p>SIGNATURE OF PHYSICIAN [Illegible Signature]</p>		<p>SIGNATURE OF REGISTRAR [Illegible Signature]</p>	

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the general director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL CERTIFICATION

21. BUCKINGHAM—WILLIAM DO THOMAS JR. STAFF CHAIRMAN

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

02018

2021

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland c. LENGTH OF STAY IN TB 10 Days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crellin d. STREET ADDRESS Box 73 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Margaret Middle Daisy Last Knotts		4. DATE OF DEATH Month February Day 10 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-23-83
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (State or foreign country) W. Va.
12. CITIZEN OF WHAT COUNTRY? America		13. FATHER'S NAME William Shaffer	
14. MOTHER'S MAIDEN NAME Julia Nordeck		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Floyd Carskadon (Son-in-law) Address Box 73, Crellin, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular disease (c) C Hypertrophy + Chronic Failure			INTERVAL BETWEEN ONSET AND DEATH 8 days 8 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1-25, 1955 , to 2-10, 1960 , that I last saw the deceased alive on 2-10, 1960 , and that death occurred at 11:05 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance M.D.		ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 2-10-60	
PHYSICIAN'S NAME (Type) Dr. Andrew E. Mance,		Oakland, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/13/1960	22c. NAME OF CEMETERY OR CREMATORY Terra Alta Cemetery	22d. LOCATION (City, town, or county) (State) Terra Alta, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE FEB 15 '60
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

200

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

02019

2028

1. PLACE OF DEATH a. COUNTY <u>Gafrrett</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Somerset</u> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantville, Md.</u>		c. LENGTH OF STAY IN 1b <u>2 months</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Springs, Penna.</u> <u>75x-3</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Goodwill Mennonite Home, Grantville</u>			d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>ETTA</u> Last <u>LOHR</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>1</u> Year <u>1960</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 19, 1885</u>		9. AGE (In years last birthday) <u>75</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	11. BIRTHPLACE (State or foreign country) <u>Bittinger, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Eli Lohr</u>			14. MOTHER'S MAIDEN NAME <u>Barbara Bender</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>none</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Emma Miller, Springs, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>3-30</u> , 19 <u>55</u> , to <u>2-1</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>1-28</u> , 19 <u>60</u> , and that death occurred at <u>10:15 AM</u> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>Leonard L Rock MD</u>		ADDRESS (Street, city or town, state) <u>209 NORTH ST</u>		DATE SIGNED <u>2/2/60</u>	
PHYSICIAN'S NAME (Type) <u>LEONARD L Rock MD</u>		<u>Meyersdale Pa</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>2/1/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Springs Mennonite</u>		22d. LOCATION (City, town, or county) (State) <u>Springs, Somerset Co., Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don J Newman</u>		ADDRESS <u>Grantville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
JAN 10 1963

Memorandum

OFFICE OF THE ATTORNEY GENERAL
STATE OF MARYLAND
JAN 10 1963

STATE OF MARYLAND
DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH

CERTIFICATE OF DEATH
JAN 10 1963

NAME OF DECEASED		DATE OF DEATH	
JAMES EARL RAY		JAN 4 1968	
AGE		SEX	
35		M	
RACE		EDUCATION	
W		H	
OCCUPATION		MANNER OF DEATH	
C		N	
PLACE OF DEATH		CITY	
H		B	
STATE		COUNTY	
MD		B	
CITY		ZIP	
B		21201	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS	
JAMES EARL RAY		3661 1/2 W. BROAD ST.	
DATE OF SIGNATURE		CITY	
JAN 10 1968		B	
STATE		COUNTY	
MD		B	
CITY		ZIP	
B		21201	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS	
JAMES EARL RAY		3661 1/2 W. BROAD ST.	
DATE OF SIGNATURE		CITY	
JAN 10 1968		B	
STATE		COUNTY	
MD		B	
CITY		ZIP	
B		21201	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2029 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02020

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R D 2 Swanton				c. LENGTH OF STAY IN 1b 50 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) North Glade Community				d. STREET ADDRESS R D #2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Morris Middle Newton Last Merrill				4. DATE OF DEATH Month February Day 20 Year 19 60			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 20, 1876		9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer & Woods worker				10b. KIND OF BUSINESS OR INDUSTRY Maryland.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME Isaac Merrill				14. MOTHER'S MAIDEN NAME Mary Savage Merrill			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT (Daughter) Address Mrs. Betty Lazelle Morgantown, W. Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH Minutes Years	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feaster Jr.</i> EXAMINER'S NAME (Type) James H. Feaster Jr., M. D.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
DATE SIGNED 2-22-60							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/1960		22c. NAME OF CEMETERY OR CREMATORY McRobie Cemetery		22d. LOCATION (City, town, or county) (State) near Swanton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>H. C. Leighton</i> ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR DATE FEB 24 '60		24b. REGISTRAR'S SIGNATURE <i>Carlton S. Pineda</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

INSTRUCTIONS

1 **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

2022

02021

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>GARRETT</u>		STATE <u>MARYLAND</u> COUNTY <u>GARRETT</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>CAKLAND</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>FRIENDSVILLE</u>	
TOWN <u>CAKLAND</u>		LENGTH OF STAY (in this place) <u>8 DAYS</u>		STREET ADDRESS <u>ROUTE #1, BOX #17</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>							
3. NAME OF DECEASED (First) (Middle) (Last) <u>BENJAMIN</u> <u>WALTER</u> <u>MEYERS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>FEB.</u> <u>10</u> <u>19 60</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>OCTOBER 16, 1889</u>	9. AGE last birthday <u>70</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER Sd.</u>		11. BIRTHPLACE (State or foreign country) <u>N. VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAAC MEYERS</u>				14. MOTHER'S MAIDEN NAME <u>ANNABELLE TEETS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-05-2294</u>		17. INFORMANT & ADDRESS <u>MRS. BENJAMIN MEYERS, FRIENDSVILLE, MD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
450.0 IMMEDIATE CAUSE (A) <u>Grima</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pneumonia -</u>				<u>10 days</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arterio sclerosis</u>				<u>10 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>NONE</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>NONE</u> M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 11</u> , 19 <u>56</u> , to <u>2-10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>2-10</u> , 19 <u>60</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>A. E. Mance</u>		M. D.		ADDRESS (Street, city, town, state) <u>Oakland Md</u>		DATE SIGNED <u>10 Feb 60</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-13-1960</u>		NAME OF CEMETERY OR CREMATORY <u>Webbs Chapel Cem.</u>		LOCATION (City, town, or county) (State) <u>Hazelton Ave</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Rodenauer - Marklyburg Pa</u>		ADDRESS	
DATE <u>FEB 15 '60</u>							

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2030

CERTIFICATE OF DEATH

Reg. Dist. No.

02022

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL OAKLAND</u>		c. LENGTH OF STAY IN 1b <u>18MO.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GUPPETT REST HOME</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE DAVID MILLER</u>		4. DATE OF DEATH Month Day Year <u>2-12-1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR. 22, 1899</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SANDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ELECTRONICS</u>	
11. BIRTHPLACE (State or foreign country) <u>MOORE, W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANKLIN MILLER</u>		14. MOTHER'S MAIDEN NAME <u>MINNIE CRAWFUS</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>232-03662</u>	
17. INFORMANT <u>MRS. G. D. MILLER, ROCKVILLE MD.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>UREMIA</u> <u>600.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>PYONEPHROSIS</u> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Jan 31</u> , 19 <u>51</u> , to <u>FEB 12</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>FEB 12</u> , 19 <u>60</u> , and that death occurred at <u>11:45</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>25 ALDER ST OAKLAND MD.</u> DATE SIGNED <u>2/12/60</u>			
ACTUAL SIGNATURE <u>E. J. BAUMGARTNER</u>		M.D. <u>25 ALDER ST</u>	
PHYSICIAN'S NAME (Type) <u>E. J. BAUMGARTNER</u>		<u>OAKLAND MD.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/15/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>MENEAUGH CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>HENDRICKS W. VA.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>St. D. Dumeau, Thomas, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 15 60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kinne</u>

2031

CERTIFICATE OF DEATH

02023

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE, MD			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JOHN CLARENCE MILLER				4. DATE OF DEATH Month FEB. Day 6 Year 1960			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 18, 1881		9. AGE (In years lost birth day) 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER		10b. KIND OF BUSINESS OR INDUSTRY MINING		11. BIRTHPLACE (State or foreign country) HOYES GARRETT CO MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN MILLER				14. MOTHER'S MAIDEN NAME MARY NATHAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-10-6221		17. INFORMANT Address MRS. IDA MILLER, GRANTSVILLE MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Acute Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/14 , 19 59 , to 2/6 , 19 60 that I last saw the deceased alive on 1/5 , 19 60 , and that death occurred at 7:00 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Meyersdale Pa DATE SIGNED CC GLASS							
ACTUAL SIGNATURE CC GLASS M.D.		PHYSICIAN'S NAME (Type) CC GLASS M.D. MEYERSDALE PA.					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 2/9/60		22c. NAME OF CEMETERY OR CREMATORY GRANTSVILLE		22d. LOCATION (City, town, or county) (State) GRANTSVILLE, GARRETT CO MD	
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman, Grantsville, Md				24a. REC'D BY REGISTRAR DATE FEB 11 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2032

CERTIFICATE OF DEATH

Reg. Dist. No.

02024

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BLOOMINGTON				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First ROBERT Middle CECIL Last MOOREHEAD				4. DATE OF DEATH Month FEB. Day 14 Year 19 60			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JAN. 17, 1883	
9. AGE (In years last birthday) yrs. 77		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired laborer				10b. KIND OF BUSINESS OR INDUSTRY W.Va. P. & P. Co BLOOMINGTON, MD.			
11. BIRTHPLACE (State or foreign country) U.S.				12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME ROBERT W. MOOREHEAD				14. MOTHER'S MAIDEN NAME MARY E. SHANHOLTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 217-05-0263			
17. INFORMANT BLOOMINGTON MD.				18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Renal Dis 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis., DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH 3mo 8yrs			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Feb 2 nd 19 60 , to Feb 14 19 60 , that I last saw the deceased alive on Feb 14 19 60 , and that death occurred at 10.30 P. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2/15 /60							
ACTUAL SIGNATURE JAS. H. WOLVERTON, SR. M.D.				PHYSICIAN'S NAME (Type) JAS. H. WOLVERTON, SR. PIEDMONT, WVA. 2/15/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF FEB. 17/60		22c. NAME OF CEMETERY OR CREMATORY PHILOS CEMETERY		22d. LOCATION (City, town, or county) (State) WESTERNPORT, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. A. Frederick Jr.				24a. REC'D BY REGISTRAR DATE FEB 16 '60		24b. REGISTRAR'S SIGNATURE Arthur E. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2082

2082

PLACE OF BIRTH		C. B. BENT	
DATE OF BIRTH		JAN. 12, 1882	
AGE		27	
SEX		MALE	
RACE		WHITE	
MARRIAGE		MARRIED	
DATE OF MARRIAGE		JAN. 12, 1882	
PLACE OF MARRIAGE		BALTIMORE, MD.	
OCCUPATION		CLOCKMAKER	
CAUSE OF DEATH		DIPHTHERIA	
PERIOD OF ILLNESS		10 DAYS	
PLACE OF DEATH		BALTIMORE, MD.	
DATE OF DEATH		JAN. 12, 1882	
TIME OF DEATH		10:00 AM	
SIGNATURE OF DECEASED		C. B. BENT	
SIGNATURE OF WITNESSES		J. W. VERNON, M.D.	
SIGNATURE OF PHYSICIAN		J. W. VERNON, M.D.	
SIGNATURE OF CORONER		J. W. VERNON, M.D.	
SIGNATURE OF JURY		J. W. VERNON, M.D.	
SIGNATURE OF JUDGE		J. W. VERNON, M.D.	
SIGNATURE OF CLERK		J. W. VERNON, M.D.	
SIGNATURE OF REGISTRAR		J. W. VERNON, M.D.	
SIGNATURE OF SHERIFF		J. W. VERNON, M.D.	
SIGNATURE OF CONSTABLE		J. W. VERNON, M.D.	
SIGNATURE OF TOWNSHIP CLERK		J. W. VERNON, M.D.	
SIGNATURE OF COUNTY CLERK		J. W. VERNON, M.D.	
SIGNATURE OF STATE CLERK		J. W. VERNON, M.D.	
SIGNATURE OF SECRETARY		J. W. VERNON, M.D.	
SIGNATURE OF ASSISTANT SECRETARY		J. W. VERNON, M.D.	
SIGNATURE OF CHIEF CLERK		J. W. VERNON, M.D.	
SIGNATURE OF DEPUTY CLERK		J. W. VERNON, M.D.	
SIGNATURE OF RECORDS CLERK		J. W. VERNON, M.D.	
SIGNATURE OF INDEXING CLERK		J. W. VERNON, M.D.	
SIGNATURE OF FILE CLERK		J. W. VERNON, M.D.	
SIGNATURE OF DISTRIBUTION CLERK		J. W. VERNON, M.D.	
SIGNATURE OF COLLECTION CLERK		J. W. VERNON, M.D.	
SIGNATURE OF ACCOUNTS CLERK		J. W. VERNON, M.D.	
SIGNATURE OF PURCHASE CLERK		J. W. VERNON, M.D.	
SIGNATURE OF SALE CLERK		J. W. VERNON, M.D.	
SIGNATURE OF RECEIPTS CLERK		J. W. VERNON, M.D.	
SIGNATURE OF GENERAL CLERK		J. W. VERNON, M.D.	
SIGNATURE OF CHIEF OF BUREAU		J. W. VERNON, M.D.	
SIGNATURE OF DEPUTY CHIEF OF BUREAU		J. W. VERNON, M.D.	
SIGNATURE OF ASSISTANT CHIEF OF BUREAU		J. W. VERNON, M.D.	
SIGNATURE OF CHIEF OF DIVISION		J. W. VERNON, M.D.	
SIGNATURE OF DEPUTY CHIEF OF DIVISION		J. W. VERNON, M.D.	
SIGNATURE OF ASSISTANT CHIEF OF DIVISION		J. W. VERNON, M.D.	
SIGNATURE OF CHIEF OF SECTION		J. W. VERNON, M.D.	
SIGNATURE OF DEPUTY CHIEF OF SECTION		J. W. VERNON, M.D.	
SIGNATURE OF ASSISTANT CHIEF OF SECTION		J. W. VERNON, M.D.	
SIGNATURE OF CHIEF OF OFFICE		J. W. VERNON, M.D.	
SIGNATURE OF DEPUTY CHIEF OF OFFICE		J. W. VERNON, M.D.	
SIGNATURE OF ASSISTANT CHIEF OF OFFICE		J. W. VERNON, M.D.	
SIGNATURE OF CHIEF OF BRANCH		J. W. VERNON, M.D.	
SIGNATURE OF DEPUTY CHIEF OF BRANCH		J. W. VERNON, M.D.	
SIGNATURE OF ASSISTANT CHIEF OF BRANCH		J. W. VERNON, M.D.	
SIGNATURE OF CHIEF OF STATION		J. W. VERNON, M.D.	
SIGNATURE OF DEPUTY CHIEF OF STATION		J. W. VERNON, M.D.	
SIGNATURE OF ASSISTANT CHIEF OF STATION		J. W. VERNON, M.D.	
SIGNATURE OF CHIEF OF DISTRICT		J. W. VERNON, M.D.	
SIGNATURE OF DEPUTY CHIEF OF DISTRICT		J. W. VERNON, M.D.	
SIGNATURE OF ASSISTANT CHIEF OF DISTRICT		J. W. VERNON, M.D.	
SIGNATURE OF CHIEF OF COUNTY		J. W. VERNON, M.D.	
SIGNATURE OF DEPUTY CHIEF OF COUNTY		J. W. VERNON, M.D.	
SIGNATURE OF ASSISTANT CHIEF OF COUNTY		J. W. VERNON, M.D.	
SIGNATURE OF CHIEF OF STATE		J. W. VERNON, M.D.	
SIGNATURE OF DEPUTY CHIEF OF STATE		J. W. VERNON, M.D.	
SIGNATURE OF ASSISTANT CHIEF OF STATE		J. W. VERNON, M.D.	
SIGNATURE OF CHIEF OF NATION		J. W. VERNON, M.D.	
SIGNATURE OF DEPUTY CHIEF OF NATION		J. W. VERNON, M.D.	
SIGNATURE OF ASSISTANT CHIEF OF NATION		J. W. VERNON, M.D.	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2033 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02025

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRANTSVILLE MD</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GRANTSVILLE, MD</u>	
c. LENGTH OF STAY IN 1b <u>LIFE</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <u>Sonya</u> Middle <u>Clair</u> Last <u>Patton</u>			4. DATE OF DEATH Month <u>Feb.</u> Day <u>14th</u> Year <u>1960</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 24 1936</u>	9. AGE (In years last birthday) <u>24</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FACTORY WORKER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>UNDER GARMENT</u>		
11. BIRTHPLACE (State or foreign country) <u>GRANTSVILLE MD</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>DAVID PAUL</u>			14. MOTHER'S MAIDEN NAME <u>BETTY PATTON</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>220-34-1372</u>		17. INFORMANT <u>Mrs. Opha Patton</u> Address <u>Grantsville, Md.</u>	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carbon Monoxide Poisoning</u> <u>891.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH Hours <u> </u>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
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20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Went to sleep in auto with motor running.</u>		
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>	Month, Day, Year <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Garage</u>	20f. (City or town) <u>Grantsville</u> (County) <u>Garr.</u> (State) <u>Md.</u>

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
DATE SIGNED <u>2-15-60</u>	

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/16/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GRANTSVILLE</u>	22d. LOCATION (City, town, or county) (State) <u>GRANTSVILLE GARRETT Co. MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don J. Newman, Grantsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>William J. Kenna</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2034

CERTIFICATE OF DEATH

Reg. Dist. No.

02026

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,				c. LENGTH OF STAY IN 1b 6 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weber Nursing Home				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Cora Middle Susan Last Reis				4. DATE OF DEATH Month February Day 9, Year 19 60			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 22, 1876	
9. AGE (In years last birthday) 83 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William H. Wright		14. MOTHER'S MAIDEN NAME Harriett Harvey		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs. Pleasant Thrasher		Address Deer Park, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio sclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7-7 , 1955 , to 2-9 , 1960 , that I last saw the deceased alive on 2-9 , 1960 , and that death occurred at 1:30 AM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 10 Feb 60			
PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D.				Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11/1960		22c. NAME OF CEMETERY OR CREMATORY Deer Park Cemetery		22d. LOCATION (City, town, or county) (State) Deer Park, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE A. C. Reighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE FEB 15 '60	
24b. REGISTRAR'S SIGNATURE C. L. H. Hume							

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Garrett Maryland.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park,		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Oakland, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weber Nursing Home		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Cora Middle Blanche Last Shaffer		4. DATE OF DEATH Month February Day 8 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 3, 1888
9. AGE (In years birthday) yrs. 71		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel W. Dodge		14. MOTHER'S MAIDEN NAME Hulda Harned	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Elmer Shaffer		Address R. D. 2 Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 600.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pyelitis DUE TO (c) Brain Tumor			INTERVAL BETWEEN ONSET AND DEATH 5 min. 3 mos. Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from October , 19 59 , to Feb 8 , 19 60 , that I last saw the deceased alive on February 5 , 19 60 , and that death occurred at 10:30 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Alfred O. Wre, Jr. M.D. Aurora, W. Va. 2-10-60 PHYSICIAN'S NAME (Type) ALFRED OWRE, JR. M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/10/1960	22c. NAME OF CEMETERY OR CREMATORY Red House Cemetery	22d. LOCATION (City, town, or county) (State) Garrett County, Md.
23. FUNERAL DIRECTOR'S SIGNATURE W. C. Keegle		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE FEB 16 '60		24b. REGISTRAR'S SIGNATURE Charles S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

STATE OF MARYLAND

DEPARTMENT OF HEALTH

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County of Baltimore

City of Baltimore

April 10, 1930

Baltimore, Md.

Death occurred at

at the residence of

2036
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland. b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gorman		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Gorman	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2 Mi. North Gorman		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Zella Middle King Last Shreve		4. DATE OF DEATH Month February Day 10 Year 19 60	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 13, 1892
9. AGE (In years last birthday) yrs. 67		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William E. King		14. MOTHER'S MAIDEN NAME Ida Everett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Edna Clark		Address Bayard, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Dehydration - Vomiting 481X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Influenza (c) Diarrhea			INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 012.1 Tuberculosis of left hip			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June 1957 to Feb. 10, 1960 , that I last saw the deceased alive on Feb. 9, 1960 , and that death occurred at 2:30 P. M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton		ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md.	
DATE SIGNED Feb 10 1960			
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M. D. Oakland, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	2/13/1960	Oak Grove Cemetery	near Gorman, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR FEB 16 1960		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

250

[illegible]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2023

CERTIFICATE OF DEATH

Reg. Dist. No.

02029

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, c. LENGTH OF STAY IN 1b 6 yrsrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural Deer Park, d. STREET ADDRESS 5 Mi. S. Deer Park e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George W. Walter				4. DATE OF DEATH Month Day Year February 16, 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 11, 1865	
9. AGE (In years last birthday) 95 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Own Farm		11. BIRTHPLACE (State or foreign country) Maryland.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Henry Walter				14. MOTHER'S MAIDEN NAME Margaret White			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ---		17. INFORMANT Lester White		Address Deer Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic C-V Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 18, 1959 to Feb 16, 1960 , that I last saw the deceased alive on Feb 15, 1960 , and that death occurred at 6:45 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Deer Park, Md. DATE SIGNED 2/18/60 ACTUAL SIGNATURE E. I. Baumgartner M.D. PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D. Oakland, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/20/1960		22c. NAME OF CEMETERY OR CREMATORY White Church Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. E. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE FEB 24 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Harris			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2021

Name of Deceased		Date of Birth	
Sex		Race	
Marital Status		Place of Birth	
Usual Residence		Date of Death	
Cause of Death		Place of Death	
Physician's Signature		Date of Certificate	
Registrar's Signature		Date of Registration	
Municipal Health Officer's Signature		Date of Filing	
County Health Officer's Signature		Date of Filing	
State Health Officer's Signature		Date of Filing	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2037

CERTIFICATE OF DEATH

Reg. Dist. No.

02030

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Virginia b. COUNTY Grant	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. La ke Park		c. LENGTH OF STAY IN 1b 2 Weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weber Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Henry Thomas Warnick		4. DATE OF DEATH Month February 25, Day 19 Year 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 5, 1875
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months 24 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Industry	
11. BIRTHPLACE (State or foreign country) Bloomington, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Vincent Warnick		14. MOTHER'S MAIDEN NAME unk.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harry J. Warnick		Address Mt. Storm W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH None	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous Cerebral Vascular Accident		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-22-60, 1960, to 2-25-60, 1960, that I lost saw the deceased alive on 2-24-60, 1960, and that death occurred at 1:30 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE James H. Feaster, Jr.		ADDRESS (Street, city or town, state) 58 2nd St. Oakland Md 2121-60	
DATE SIGNED 2-27-60		M.D.	
PHYSICIAN'S NAME (Type) James H. Feaster, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/28/60	
22c. NAME OF CEMETERY OR CREMATORY Sheffer Cemetery		22d. LOCATION (City, town, or county) (State) Mt. Storm W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home		ADDRESS Oakland, Maryland	
24a. REC'D BY REGISTRAR MAR 1 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

02031

1. PLACE OF DEATH o. COUNTY Garrett 2039 MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Swanton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rt # 1. Oakland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Robert Middle Carl Last Winters		4. DATE OF DEATH Month 2 Day 19 Year 1960	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 21, 1906
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 53 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) carpenter		10b. KIND OF BUSINESS OR INDUSTRY Building	
11. BIRTHPLACE (State or foreign country) W. Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Raymond Winters		14. MOTHER'S MAIDEN NAME Ellazan Houser	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-12-2070	
17. INFORMANT Mary Winters		Address Swallow Falls, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____</p> </div> <div style="width: 15%;"> <p>INTERVAL BETWEEN ONSET AND DEATH Mins.</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____</p>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		DATE SIGNED 2-20-60	
EXAMINER'S NAME (Type) James H. Feaster, Jr., M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/22/60	22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery	22d. LOCATION (City, town, or county) (State) Oakland Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR FEB 24 '60		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Harris</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH
 HAWAIIAN STATE DEPARTMENT OF HEALTH—BALTIMORE, MD